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TO: John Auerbach, Commissioner, MDPH

FROM: Steven Chilian, Deputy General Counsel

RE: Investigation - Lab Breach in Protocols

DATE: February 29, 2012

CONFIDENTIAL MEMORANDUM

On December 1, the Department of Public Health (MDPH) became aware of an alleged irregularity in the Lab's protocols for documenting the transfer of samples submitted for forensic analysis for criminal proceedings. The Department has conducted an investigation to determine the validity of this allegation.

I. INVESTIGATION PROCESS

A. Persons Interviewed: The following persons were interviewed by me as part of this investigation and the information provided by them is incorporated herein. Union protocols were observed for all interviews. Their statements or interview summaries are attached as exhibits to this report.

1. Linda Han, Lab Director (Boston)
2. Julianne Nassif, Program Manager (Boston)
3. Charles Salemi, Lab Supervisor II (Boston)
4. Shirley Sprague, Administrative Assistant II (Boston)
5. Elizabeth O'Brien, Laboratory Supervisor I (Boston)
6. Gloria Philips, Administrative Assistant I (Boston)

7. Annie Dookhan, Chemist II (Boston)

B. Documents: Documents reviewed during this investigation include, but are not limited to, the following:

1. Relevant Statutes (M.G.L. chapter 111, sections 12 and 13)
2. Policies and Procedures – Drug Analysis Laboratories – Updated 9/24/2004
3. Copy of the relevant log book pages
4. Time Logs for Lab employees for period of June 14 to June 25

II. ALLEGATION INVESTIGATED

Whether the transfer of a number of samples from the evidence office to the Lab for testing was properly assigned and recorded in accordance with Lab protocols.

III. FINDINGS:

A. The MDPH Drug Forensic Lab (Lab) is authorized pursuant to M.G.L. Chapter 111, sections 12 and 13 to provide chemical analysis to police authorities for the purpose of enforcement of law.

B. Annie Dookhan (AD) is a Chemist II whose duties at the Lab at the time of the alleged event were to analyze samples submitted to the Lab for forensic testing. AD has held this position for eight years. During her tenure as chemist she has had an exemplary record of performance and was highly regarded by her peers for her work ethic and professionalism. She has no record of any disciplinary actions. It should also be noted that in the last two years she suffered both the loss of a child and the break-up of her marriage.

C. The Lab's protocols for handling samples requires that all samples received by the Lab for testing be given a unique sample identifier called an evidence control number (control number). The Lab uses this number to track the case samples as they undergo the testing process. All transfers of samples to and from the evidence office are required to be entered into the Lab's computer tracking system by an evidence officer and manually recorded in the office log book (log book). The log book contains a list of all samples (by sample control number) received at the Lab for testing. The evidence officer is required to record his/her initials, the date of the transfer and the initials of the person accepting receipt of the sample(s). The person receiving the sample is required in the presence of the evidence officer to record his/her initials signifying his/her receipt.

D. The Lab became aware of a potential breach in its protocol on June 16, 2011 by evidence officer, Shirley Sprague (SS). The discovery was made by SS while entering information into

the Lab's computer from a number of evidence control cards. [1] When SS scanned the evidence envelope's bar code into the computer, the information displayed on the computer for that case did not show the sample(s) for that case as having been assigned to the chemist identified on the control card. SS had to manually input the chemist's name into the computer. This is not a necessary step when the samples are properly scanned out to the chemist by the evidence officer. SS repeated this process for a number of samples. SS also examined the log book. There were no entries to the right of the control numbers for these samples recording their transfer from the evidence office to the chemist for testing. SS contacted her supervisor, Elizabeth O'Brien (EO), by telephone to alert her of this irregularity. The primary chemist listed on the control cards as having custody of these samples was AD.

E. EO met with SS in the evidence office that same day, June 16th, and confirmed SS's findings, i.e., there was no record of the transfer of these samples to AD in either the Lab's computer tracking system or the log book.[2] On June 20th, EO met with Charles Salemi (CS), Supervising Chemist for the Analysis Section, and Julie Nassif (JN), the Lab's Director of the Division of Analytic Chemistry, to brief them about the discovery. EO brought the log book to the meeting to show both JN and CS. At the time of this meeting, there were no entries in the log book documenting the transfer of the samples from an evidence officer to AD.

F. When the log book was re-examined again on June 21, there were now entries recording their transfer from Gloria Philips (GP) to AD on June 14. A review of GP's time logs showed GP to be on leave from June 15 until June 27. Therefore, GP was unable to have made these entries.

G. GP maintains that she was on leave between June 15 and June 27 and therefore unable to have written the entries on the 21st. Her time sheets confirm her absence from work during this period. GP was also asked to review the log book, specifically the transfers purportedly

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[1] All samples are transferred in evidence envelopes that are bar coded with each sample's unique identification (control) number and are accompanied with a control card that contains the test result, the date the sample was received by the lab, the date analyzed, test result and the initials of the chemists that performed the test(s). The primary chemist who is assigned the sample performs the preliminary test(s). A separate chemist performs the confirmation test(s). The evidence envelopes are kept in the custody of the primary chemist in the chemist's lab evidence locker (a locked cabinet) while waiting testing. The results of the analysis are provided to the requesting law enforcement agency in the form of a certificate of analysis that certifies what the samples contained and its net weight. The certificate is signed by both chemists.

[2] The samples in question totaled 90.

made by her to AD on June 14. GP stated that the initials purporting to be hers had been written by someone else.

H. The log book is kept in the evidence room. AD, as do all Lab staff, have access to the evidence room via a palm reader. The evidence room is normally staffed by two evidence officers. The number of evidence officers working on the 20th of June was one and the number working on June 21st was two, with one evidence officer working a half-day. The short staffing provided a greater opportunity to enter the evidence office without being observed.

I. AD verified her initials in the log book, but indicated that she may have initialed her receipt "after the fact". That is, although the log book shows that the date of her receipt was June 14, 2011, she likely initialed her receipt for them on a later date. She acknowledged that she had seen the entry by GP but denied that it was written by her. She had no explanation as to who may have made the entry.

J. AD was temporarily removed from her testing duties on or about June 21 and assigned other administrative duties. AD was placed on administrative leave on February 21, 2012.

K. AD has not testified in any cases involving the 90 samples. The certificate of analysis (certificate) routinely produced by the Lab for each of the tested samples and signed by AD certified what the sample was found to contain and its net weight.

L. The Commissioner's office first became aware of this incident on December 1, as a result of inquiries made by the Lab to Human Resources concerning the possible reassignment of AD in early December. The Lab's failure to report this incident to Central Office was based on the Lab's lack of appreciation for its potential legal significance and their opinion that the integrity of the test results had not been affected. There is no evidence to suggest that the integrity of the results were impacted by the documentation issue with the log book.

M. The Lab has taken a number of steps to minimize any reoccurrence of this nature. The Lab has revised its protocol for handling test samples, to include a protocol for reporting discrepancies and has instituted a new policy that limits access to the evidence office to evidence officers only with all transfers of samples to chemists for testing conducted through the evidence office service window. Finally the Lab is also looking at the cost feasibility of adding new security measures such as surveillance cameras.

III CONCLUSIONS

Based on a preponderance of the evidence collected during the course of this investigation through interviews and review of documentation, it can be concluded that AD failed to follow Lab protocols for the transfer and documentation of samples for testing, and subsequently created a false record of said transfers. The facts support that the log book was examined by three persons after June 16 and prior to June 21, each of whom stated that there were no written entries next to the sample control numbers for the identified samples that documented their transfer for testing to AD. When the log book was re-examined again on June 21, the previously blank pages for these samples were "filled in". The log book now showed them as having been transferred from GP to AD on June 14. GP could not have written these entries as she was on leave from June 15th through the 27th and, as noted in the findings section, was emphatic after having reviewed the log book that the entries were not in her hand writing. Finally, visual inspection of the log entries supports that the entries for GP and AD were likely written by the same person. While AD did not claim responsibility for writing GP's initials she did verify that the initials signifying her receipt of the samples was in her handwriting and acknowledged that their handwriting is similar. If you eliminate GP as authoring the log entries, the only person with both motive and opportunity to have completed them is AD. The most likely scenario as supported by the evidence is that AD retrieved the samples from the evidence office for testing without following Lab protocols and later compounded this error by creating false documentation of the transfer after the fact.